		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031823

Facility Name: WINDMILL NURSING PAVILION

Address: 16000 S. WABASH (Number) SOUTH HOLLAND (City) 60473 (Zip Code)

County: COOK

Telephone Number: (847) 679-8219 **Fax #** (847) 679-7377

IDPA ID Number: 36-3485403

Date of Initial License for Current Owners: 01/02/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT		X	PROPRIETARY		GOVERNMENTAL	
	Charitable Corp.			Individual		State	
	Trust			Partnership		County	
IRS Exemption Code				Corporation		Other	
			X	"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MARSHALL MAUER
(Title) TREASURER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,439	2,439	8
9	SNF/PED					9
10	ICF	42,972	2,700	246	45,918	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,972	2,700	2,685	48,357	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.32%

D. How many bed-hold days during this year were paid by Public Aid?
503 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/2/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/2/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 13 and days of care provided 1,945

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	181,676	15,591	6,369	203,636		203,636		203,636			1
2	Food Purchase		199,914		199,914	(26,061)	173,853	(938)	172,915			2
3	Housekeeping	17,732	20,188		37,920		37,920		37,920			3
4	Laundry		16,522	76,451	92,973		92,973		92,973			4
5	Heat and Other Utilities			104,076	104,076		104,076	1,058	105,134			5
6	Maintenance	57,396	25,411	144,704	227,511		227,511	11,178	238,689			6
7	Other (specify):*			12,487	12,487		12,487	704	13,191			7
8	TOTAL General Services	256,804	277,626	344,087	878,517	(26,061)	852,456	12,002	864,458			8
	B. Health Care and Programs											
9	Medical Director			600	600		600		600			9
10	Nursing and Medical Records	1,714,813	57,587	25,205	1,797,605		1,797,605	(2,542)	1,795,063			10
10a	Therapy	16,402	422	32,859	49,683		49,683	(534)	49,149			10a
11	Activities	111,802	7,542	1,586	120,930		120,930		120,930			11
12	Social Services	32,638		2,860	35,498		35,498		35,498			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,875,655	65,551	63,110	2,004,316		2,004,316	(3,076)	2,001,240			16
	C. General Administration											
17	Administrative	107,646		120,000	227,646		227,646	91,745	319,391			17
18	Directors Fees											18
19	Professional Services			70,152	70,152		70,152	(5,175)	64,977			19
20	Dues, Fees, Subscriptions & Promotions			59,372	59,372		59,372	(33,237)	26,135			20
21	Clerical & General Office Expenses	120,258	14,232	273,556	408,046		408,046	(197,461)	210,585			21
22	Employee Benefits & Payroll Taxes			469,979	469,979	26,061	496,040		496,040			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,019	4,019		4,019	282	4,301			24
25	Other Admin. Staff Transportation			934	934		934		934			25
26	Insurance-Prop.Liab.Malpractice			137,517	137,517		137,517	3,484	141,001			26
27	Other (specify):*							25,905	25,905			27
28	TOTAL General Administration	227,904	14,232	1,135,529	1,377,665	26,061	1,403,726	(114,457)	1,289,269			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,360,363	357,409	1,542,726	4,260,498		4,260,498	(105,531)	4,154,967			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WINDMILL NURSING PAVILION #0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			62,574	62,574		62,574	98,078	160,652			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,936	22,936		22,936	469,442	492,378			32
33	Real Estate Taxes			296,495	296,495		296,495	3,078	299,573			33
34	Rent-Facility & Grounds			841,200	841,200		841,200	(841,200)				34
35	Rent-Equipment & Vehicles			4,496	4,496		4,496	9,004	13,500			35
36	Other (specify):*											36
37	TOTAL Ownership			1,227,701	1,227,701		1,227,701	(261,598)	966,103			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		54,600	100,276	154,876		154,876	(2,629)	152,247			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		54,600	182,401	237,001		237,001	(2,629)	234,372			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,360,363	412,009	2,952,828	5,725,200		5,725,200	(369,758)	5,355,442			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(95,413)	30		9
10	Interest and Other Investment Income	(873)	32		10
11	Discounts, Allowances, Rebates & Refunds	(456)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(482)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(400)	21		18
19	Entertainment		20		19
20	Contributions	(6,680)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(7,326)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(27,276)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	658			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (138,248)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(231,510)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (231,510)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (369,758)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

WINDMILL NURSING PAVILION

ID# 0031823

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 658	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	658		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(938)	0	0	0	0	0	0	0	0	0	0	(938)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,058	0	0	0	0	0	0	0	0	1,058	5
6	Maintenance	658	0	3,244	7,276	0	0	0	0	0	0	0	11,178	6
7	Other (specify):*	0	0	85	0	619	0	0	0	0	0	0	704	7
8	**TOTAL General Services**	(280)	0	4,387	7,276	619	0	0	0	0	0	0	12,002	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	(2,542)	0	0	0	0	0	(2,542)	10
10a	Therapy	0	0	0	0	0	(534)	0	0	0	0	0	(534)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	(3,076)	0	0	0	0	0	(3,076)	16
	C. General Administration													
17	Administrative	0	(100,800)	0	192,545	0	0	0	0	0	0	0	91,745	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,326)	0	2,151	0	0	0	0	0	0	0	0	(5,175)	19
20	Fees, Subscriptions & Promotions	(33,956)	0	719	0	0	0	0	0	0	0	0	(33,237)	20
21	Clerical & General Office Expenses	(400)	(245,800)	42,187	6,552	0	0	0	0	0	0	0	(197,461)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	282	0	0	0	0	0	0	0	0	282	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,484	0	0	0	0	0	0	0	0	3,484	26
27	Other (specify):*	0	0	7,251	0	18,654	0	0	0	0	0	0	25,905	27
28	**TOTAL General Administration**	(41,682)	(346,600)	56,074	199,097	18,654	0	0	0	0	0	0	(114,457)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(41,962)	(346,600)	60,461	206,373	19,273	(3,076)	0	0	0	0	0	(105,531)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(95,413)	188,716	4,775	0	0	0	0	0	0	0	0	98,078	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(873)	466,114	4,201	0	0	0	0	0	0	0	0	469,442	32
33	Real Estate Taxes	0	0	3,078	0	0	0	0	0	0	0	0	3,078	33
34	Rent-Facility & Grounds	0	(841,200)	0	0	0	0	0	0	0	0	0	(841,200)	34
35	Rent-Equipment & Vehicles	0	0	9,004	0	0	0	0	0	0	0	0	9,004	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(96,286)	(186,370)	21,058	0	0	0	0	0	0	0	0	(261,598)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	(2,629)	0	0	0	0	0	(2,629)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	(2,629)	0	0	0	0	0	(2,629)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(138,248)	(532,970)	81,519	206,373	19,273	(5,705)	0	0	0	0	0	(369,758)	45

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		SCHEDULE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEE	$ 100,800	DYNAMIC HEALTHCARE CONSULTANTS		$	$ (100,800)	1
2	V	21	BOOKEEPING SVC	245,800	" " "			(245,800)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V	34	RENT	841,200	16000 S. WABASH PARTNERSHIP			(841,200)	7
8	V				" " "				8
9	V	30	DEPRECIATION		" " "		188,716	188,716	9
10	V	32	INTEREST		" " "		466,114	466,114	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,187,800			$ 654,830	$ * (532,970)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 1,058	$ 1,058	15
16	V	6	REPAIRS & MAINTENANCE		" " "	100.00%	3,244	3,244	16
17	V	7	EMP. BEN. - GEN. SERVICES		" " "	100.00%	85	85	17
18	V	19	PROFESSIONAL FEES		" " "	100.00%	2,151	2,151	18
19	V	20	DUES & SUBSCRIPTION		" " "	100.00%	719	719	19
20	V	21	CLERICAL & GENERAL		" " "	100.00%	42,187	42,187	20
21	V	24	SEMINAR & TRAVEL		" " "	100.00%	282	282	21
22	V	26	INSURANCE		" " "	100.00%	3,484	3,484	22
23	V	27	EMP. BEN.- GEN. ADMIN		" " "	100.00%	7,251	7,251	23
24	V	30	DEPRECIATION		" " "	100.00%	4,775	4,775	24
25	V	32	INTEREST		" " "	100.00%	4,201	4,201	25
26	V	33	REAL ESTATE TAXES		" " "	100.00%	3,078	3,078	26
27	V	35	EQUIPMENT RENTAL		" " "	100.00%	9,004	9,004	27
28	V				" " "				28
29	V				" " "				29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 81,519	$ * 81,519	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP.- D. NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 7,276	$ 7,276	15
16	V	10	NURSING CMP.- SUE G.		" " "	100.00%			16
17	V	17	ADMIN. CMP.- M. MAUER		" " "	100.00%	40,668	40,668	17
18	V	17	ADMIN. CMP.- M. AARON		" " "	100.00%	60,145	60,145	18
19	V	17	ADMIN. CMP.- F. AARON		" " "	100.00%	42,958	42,958	19
20	V	17	ADMIN. CMP.- S. GOLDSTEIN		" " "	100.00%			20
21	V	17	ADMIN. CMP.- S. KOPLIN		" " "	100.00%			21
22	V	17	ADMIN. CMP.- D. MAGAFAS		" " "	100.00%	13,601	13,601	22
23	V	17	ADMIN. CMP.- E. CASSON		" " "	100.00%			23
24	V	17	ADMIN. CMP.- S. BOGEN		" " "	100.00%			24
25	V	17	ADMIN. CMP.- S. LEVY		" " "	100.00%	15,744	15,744	25
26	V	17	ADMIN. CMP.- H. ALTER		" " "	100.00%			26
27	V	17	ADMIN. CMP.- NON-OWNER		" " "	100.00%	19,429	19,429	27
28	V	21	CLERICALCMP.- S. AARON		" " "	100.00%	6,552	6,552	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 206,373	$ * 206,373	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN. - D.NEHMER	$	DYNAMIC HEALTHCARE CONSULTANTS	100.00%	$ 619	$ 619	15
16	V	15	EMP. BEN. - SUE.G.		" " "	100.00%			16
17	V	27	EMP. BEN. - M.MAUER		" " "	100.00%	1,768	1,768	17
18	V	27	EMP. BEN. - M.AARON		" " "	100.00%	2,254	2,254	18
19	V	27	EMP. BEN. - F. AARON		" " "	100.00%	6,346	6,346	19
20	V	27	EMP. BEN. - S.GOLDSTEIN		" " "	100.00%			20
21	V	27	EMP. BEN. - S.KOPLIN		" " "	100.00%			21
22	V	27	EMP. BEN. - D.MAGAFAS		" " "	100.00%	1,886	1,886	22
23	V	27	EMP. BEN. - E. CASSON		" " "	100.00%			23
24	V	27	EMP. BEN. - S. BOGEN		" " "	100.00%			24
25	V	27	EMP. BEN. - S.LEVY		" " "	100.00%	2,273	2,273	25
26	V	27	EMP. BEN. - A.STEINER		" " "	100.00%			26
27	V	27	EMP. BEN. - NON-OWNER		" " "	100.00%	2,897	2,897	27
28	V	27	EMP. BEN. - S. AARON		" " "	100.00%	1,230	1,230	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 19,273	$ * 19,273	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a	THERAPY	$ 29,723	DYNAMIC REHAB CONSULTANTS LLC	100.00%	$ 29,189	$ (534)	15
16	V	22	EMPLOYEE BENEFITS		" " " "	100.00%			16
17	V	39	ANCILLARY SERVICES	78,740	" " " "	100.00%	77,326	(1,414)	17
18	V								18
19	V								19
20	V	10	MEDICAL SUPPLIES	17,629	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	15,087	(2,542)	20
21	V	39	ANCILLARY EXPENSE	8,428	" "	100.00%	7,213	(1,215)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 134,520			$ 128,815	$ * (5,705)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARSHALL MAUER		ADMINISTRATIVE			SCHEDULE ATTACHED		SALARY	$ 40,668	17-7	1
2	MAURICE AARON		ADMINISTRATIVE					SALARY	60,145	17-7	2
3	FRED AARON		ADMINISTRATIVE					SALARY	42,958	17-7	3
4	" "							MGMT FEE	19,200	17-3	4
5	SHARON AARON		CLERICAL					SALARY	6,552	21-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 169,523		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	TOTAL PATIENT DAYS	441,841	13	$ 9,671	$	48,357	$ 1,058	1
2	6	REPAIR & MAINTENANCE	" "	441,841	13	29,639	2,150	48,357	3,244	2
3	7	EMP. BEN. - GEN. SVCS.	" "	441,841	13	778		48,357	85	3
4	19	PROFESSIONAL FEES	" "	441,841	13	19,651		48,357	2,151	4
5	20	DUES & SUBSCRIPTION	" "	441,841	13	6,566		48,357	719	5
6	21	CLERICAL & GENERAL	" "	441,841	13	385,463	300,175	48,357	42,187	6
7	24	SEMINAR & TRAVEL	" "	441,841	13	2,576		48,357	282	7
8	26	INSURANCE	" "	441,841	13	31,835		48,357	3,484	8
9	27	EMP. BEN. - GEN.ADMIN.	" "	441,841	13	66,254		48,357	7,251	9
10	30	DEPRECIATION	" "	441,841	13	43,634		48,357	4,775	10
11	32	INTEREST	" "	441,841	13	38,384		48,357	4,201	11
12	33	REAL ESTATE TAXES	" "	441,841	13	28,121		48,357	3,078	12
13	35	EQUIPMENT RENTAL	" "	441,841	13	82,269		48,357	9,004	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 744,841	$ 302,325		$ 81,519	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

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Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP.- D.NEHMER	WGHTD. AVG. HOURS	40	10	$ 59,032	$ 59,032	5	$ 7,276	1
2	10	NURSING - SUE G.	" " "	40	1	32,744	32,744			2
3	17	ADMIN. CMP.- M. MAUER	" " "	40	12	363,103	363,103	4	40,668	3
4	17	ADMIN. CMP.- M. AARON	" " "	40	10	487,988	487,988	5	60,145	4
5	17	ADMIN. CMP.- F. AARON	" " "	45	6	193,312	193,312	10	42,958	5
6	17	ADMIN. CMP.- S.GOLDSTEIN	" " "	37	2	153,497	153,497			6
7	17	ADMIN. CMP.- S.KOPLIN	" " "	40	8	71,542	71,542			7
8	17	ADMIN. CMP.- D. MAGAFAS	" " "	45	9	87,437	87,437	7	13,601	8
9	17	ADMIN. CMP.- E. CASSON	" " "	38	1	31,246	31,246			9
10	17	ADMIN. CMP. -S. BOGEN	" " "	45	2	54,060	54,060			10
11	17	ADMIN. CMP.- S.LEVY	" " "	45	12	140,632	140,632	5	15,744	11
12	17	ADMIN. CMP.- H. ALTER	" " "	40	1	12,000	12,000			12
13	17	ADMIN. CMP.- NON-OWNER	" " "	45	12	157,563	157,563	6	19,429	13
14	21	CLERICAL CMP.- S.AARON	" " "	40	12	58,502	58,502	4	6,552	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,902,658	$ 1,902,658		$ 206,373	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

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Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN. - D.NEHMER	WGHTD. AVG. HOURS	40	10	$ 5,020	$	5	$ 619	1
2	15	EMP. BEN. - SUE G.	" " "	40	1	3,128				2
3	27	EMP. BEN. - M.MAUER	" " "	40	12	15,782		4	1,768	3
4	27	EMP. BEN. - M.AARON	" " "	40	10	18,288		5	2,254	4
5	27	EMP. BEN. - F. AARON	" " "	45	6	28,556		10	6,346	5
6	27	EMP. BEN. - S.GOLDSTEIN	" " "	37	2	25,672				6
7	27	EMP. BEN. - S.KOPLIN	" " "	40	8	22,644				7
8	27	EMP. BEN. - D.MAGAFAS	" " "	45	9	12,125		7	1,886	8
9	27	EMP. BEN. - E.CASSON	" " "	38	1	3,418				9
10	27	EMP. BEN. - S.BOGEN	" " "	45	2	5,010				10
11	27	EMP. BEN. - S.LEVY	" " "	45	12	20,299		5	2,273	11
12	27	EMP. BEN. - H. ALTER	" " "	40	1	1,296				12
13	27	EMP. BEN. - NON-OWNER	" " "	45	12	23,491		6	2,897	13
14	27	EMP. BEN. - S. AARON	" " "	40	12	10,982		4	1,230	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 195,711	$		$ 19,273	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTHCARE CONSULTANTS
Street Address: 3359 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		DYNAMIC REHAB CONSULTANTS				$	$		$	1
2	10a	THERAPY	DIRECT ALLOCATION						29,189	2
3	22	EMPLOYEE BENEFITS	" "							3
4	39	ANCILLARY SERVICES	" "						77,326	4
5										5
6										6
7		LINCOLN MEDICAL SUPPLIES								7
8	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						15,087	8
9	39	ANCILLARY EXPENSE	" "						7,213	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 128,815	25

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	AMERICAN NATIONAL BANK		X	MORTGAGE	$55,899.00	10/00	$ 5,625,000	$ 5,203,380		8.6500	$ 466,114	1
2												2
3												3
4												4
5												5
	Working Capital											
6	AMERICAN NATIONAL BANK		X	WORKING CAPITAL	DEMAND			106,319		PRIME+	20,192	6
7	UPAC		X	INSURANCE FINANCING							2,744	7
8												8
9	TOTAL Facility Related				$55,899.00		$ 5,625,000	$ 5,309,699			$ 489,050	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,625,000	$ 5,309,699			$ 489,050	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 251,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 269,495	2
3. Under or (over) accrual (line 2 minus line 1).		$ 18,495	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 278,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 296,495	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	224,837	8
	1998	232,380	9
	1999	237,206	10
	2000	244,044	11
	2001	269,495	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WINDMILL NURSING PAVILION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031823

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	29-15-302-051-0000	NURSING HOME	$ 269,495.00	$ 269,495.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 269,495.00	$ 269,495.00

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 44,054 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 354,221	1
2					2
3	TOTALS			$ 354,221	3

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1986	1976	$ 3,187,988	$ 188,716	30	$ 106,266	$ (82,450)	$ 1,593,990	4
5											5
6											6
7											7
8					48,550	1,245	35	1,387	142	12,946	8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENT			1989	6,334	201	31.5	201		2,705	9
10	LEASEHOLD IMPROVEMENT			1990	1,538	49	20	77	28	730	10
11	LEASEHOLD IMPROVEMENT			1991	26,695	848	20	1,335	487	12,187	11
12	LEASEHOLD IMPROVEMENT			1992	4,785	152	20	239	87	2,031	12
13	LEASEHOLD IMPROVEMENT			1993	8,024	255	31.5	255		2,490	13
14	LEASEHOLD IMPROVEMENT			1993	36,822	944	39	944		8,837	14
15	LEASEHOLD IMPROVEMENT			1994	38,826	996	39	996		8,161	15
16	LEASEHOLD IMPROVEMENT			1995	21,539	553	39	553		4,237	16
17	FLOOR MOUNTED TANK, WALL MOUNTED SINK, CONDENSOR			1996	1,604	41	39	41		279	17
18	ROOF REPAIR			1996	3,800	97	39	97		627	18
19	GAZEBO			1996	1,282	33	39	33		210	19
20	ASPHALT REMOVE & REPLACE			1996	2,686	69	39	69		435	20
21	ROOF REPAIR			1996	7,000	179	39	179		1,126	21
22	HOT WATER TANK			1996	12,098	310	39	310		1,899	22
23	CABINETS, SINK, COUNTERTOP, SHELVES			1997	6,844	175	39	175		926	23
24	REHAB ROOM, FLOORING,HAND RAILS			1997	105,092	2,695	39	2,695		14,331	24
25	ROOFING			1997	45,500	1,167	39	1,167		6,176	25
26	FLOOR TILES, DOORS, WINDOW TREATMENTS			1997	4,721	121	39	121		640	26
27	FIRE ALARM, AIR UNIT, LAUNDRY REPAIRS			1997	26,497	679	39	679		3,593	27
28	FIRE ALARM REPAIR, DOOR ALARM			1998	3,359	86	39	86		381	28
29	DRAPES & INSTALLATION			1998	5,965	153	39	153		667	29
30	FLOOR TILE, HAND RAILS, DOOR MAGNETS, ROOM SIGNS			1998	14,240	365	39	365		1,594	30
31	EXHAUST FAN & INSTALLATION			1998	2,285	59	39	59		248	31
32	ROOF REPAIR			1998	8,750	224	39	224		982	32
33	DRYWALL,PLASTER,PAINT,WALLPAPER HALLWAYS			1998	22,500	577	39	577		2,540	33
34	ELECTRICAL WORK			1998	5,376	138	39	138		601	34
35	COUNTER TOPS			1998	712	18	39	18		78	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PARKING LOT IMPROVEMENT	1999	$ 1,185	$ 30	39	$ 30	$	$ 120	37
38	NURSES STATION	1999	16,601	426	39	426		1,687	38
39	ALUMINUM WINDOWS	1999	4,740	122	39	122		386	39
40	FIRE SYSTEM	1999	2,625	67	39	67		264	40
41	FLOOR TILE	1999	10,807	277	39	277		1,097	41
42	DOOR AND MAGNET	1999	9,601	246	39	246		916	42
43	ELECTRICAL WORK IN KITCHEN	1999	8,850	227	39	227		792	43
44	AIR CONDITIONING	1999	14,451	371	39	371		1,371	44
45	RAILINGS	1999	3,282	84	39	84		305	45
46	ROOF WORK	1999	4,500	115	39	115		379	46
47	NURSE STATION	2000	7,090	258	27.5	258		657	47
48	ALARM REPAIR/CAMERA/ANNUNCIATOR	2000	6,344	231	27.5	231		592	48
49	ROOF REPAIR	2000	8,378	304	27.5	304		781	49
50	PAVEMENT PATCH	2000	2,580	94	27.5	94		239	50
51	SMOKE DETECTOR	2000	3,472	126	27.5	126		320	51
52	FENCE, TREE REMOVAL, YARD & GARDEN WORK	2001	6,271	418	15	418		627	52
53	DOORS, DOOR RELEASE	2001	5,661	206	27.5	206		284	53
54	ROOF REPAIRS	2001	5,750	209	27.5	209		292	54
55	WALL AIRCONDITINER	2001	2,913	106	27.5	106		143	55
56	VALVE,ALARM,PIPE REPAIR	2001	5,720	208	27.5	208		289	56
57	SINK, SHELVES, CASES	2001	2,423	88	27.5	88		118	57
58	CONCRETE PAD	2002	1,662	55	15	55		55	58
59	ELECTRIC MOTOR	2002	714	9	27.5	9		9	59
60	WALL HEATER / AC	2002	3,705	18	27.5	18		18	60
61	ROOF REPAIRS	2002	5,550	76	27.5	76		76	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,806,287	$ 205,516		$ 123,810	$ (81,706)	$ 1,697,464	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 336,807	$ 40,859	$ 30,759	$ (10,100)		$ 248,999	71
72	Current Year Purchases	30,799	6,160	1,540	(4,620)		1,540	72
73	Fully Depreciated Assets	208,652					208,652	73
74	RELATED PARTY	28,833	1,793	2,489	696		17,959	74
75	TOTALS	$ 605,091	$ 48,812	$ 34,788	$ (14,024)		$ 477,150	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RELATED PARTY			$ 6,161	$ 1,737	$ 2,054	$ 317		$ 4,275	76
77										77
78										78
79										79
80	TOTALS			$ 6,161	$ 1,737	$ 2,054	$ 317		$ 4,275	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,771,760	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 256,065	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 160,652	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (95,413)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,178,889	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 4,496 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service		Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs		$		$ 24,810	$		$ 24,810	1
2	Licensed Speech and Language Development Therapist	39-3	hrs				2,871			2,871	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs				68,959			68,959	4
5	Physician Care	39-3	visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-3	# of prescrpts					33,681		33,681	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program							0			12
13	LAB, XRAY, MEDICAL SUPPLIES Other (specify):	39-2 &3						24,555		24,555	13
14	TOTAL				$		$ 96,640	$ 58,236		$ 154,876	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number WINDMILL NURSING PAVILION **#** 0031823 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 53,505	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	669,742		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	52,945		6
7	Other Prepaid Expenses	2,825		7
8	Accounts Receivable (owners or related parties)	51,000		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 830,017	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	569,749		15
16	Equipment, at Historical Cost	599,761		16
17	Accumulated Depreciation (book methods)	(573,576)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 595,934	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,425,951	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 296,566	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	450,000		29
30	Accrued Salaries Payable	175,184		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,159		31
32	Accrued Real Estate Taxes(Sch.IX-B)	278,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,206,909	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,206,909	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 219,042	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,425,951	$	48

***(See instructions.)**

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 602,101	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 602,101	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(320,059)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(63,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (383,059)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 219,042	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,367,212	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,367,212	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	36,600	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 36,600	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	873	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 873	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNT EARNED	456	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 456	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,405,141	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	878,517	31
32	Health Care	2,004,316	32
33	General Administration	1,377,665	33
	B. Capital Expense		
34	Ownership	1,227,701	34
	C. Ancillary Expense		
35	Special Cost Centers	154,876	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,725,200	40
41	**Income before Income Taxes (line 30 minus line 40)****	(320,059)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (320,059)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,925	1,882	$ 59,858	$ 31.81	1
2	Assistant Director of Nursing	2,688	2,953	61,389	20.79	2
3	Registered Nurses	2,772	2,725	53,045	19.47	3
4	Licensed Practical Nurses	37,544	40,506	746,461	18.43	4
5	Nurse Aides & Orderlies	81,277	86,368	779,027	9.02	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	684	702	16,402	23.36	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,664	1,672	20,461	12.24	9
10	Activity Assistants	10,871	11,868	91,341	7.70	10
11	Social Service Workers	2,432	2,481	32,638	13.16	11
12	Dietician					12
13	Food Service Supervisor	1,956	2,205	31,668	14.36	13
14	Head Cook	2,467	2,490	23,092	9.27	14
15	Cook Helpers/Assistants	14,967	16,566	126,916	7.66	15
16	Dishwashers					16
17	Maintenance Workers	3,766	4,177	57,396	13.74	17
18	Housekeepers	2,570	2,756	17,732	6.43	18
19	Laundry					19
20	Administrator	1,895	2,158	65,677	30.43	20
21	Assistant Administrator	2,133	2,388	41,969	17.57	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,207	8,921	120,258	13.48	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,261	1,620	15,033	9.28	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	181,079	194,438	$ 2,360,363 *	$ 12.14	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	247	$ 5,772	1-3	35
36	Medical Director	12	600	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant	69	2,208	10-3	38
39	Pharmacist Consultant	140	5,580	10-3	39
40	Physical Therapy Consultant	195	10,698	10a-3	40
41	Occupational Therapy Consultant	346	19,026	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	55	3,135	10a-3	43
44	Activity Consultant	35	1,586	11-3	44
45	Social Service Consultant	52	2,860	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,150	$ 51,465		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides	937	17,417	10-3	52
53	TOTAL (lines 50 - 52)	937	$ 17,417		53

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ANN MARIE HARRINGTON	ADMIN	0	$ 65,677
JOYCE MCGEE	ASST ADMIN	0	41,969
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 107,646

B. Administrative - Other

Description	Amount
MANAGEMENT FEE	$ 100,800
FRED AARON - MANAGEMENT FEE	19,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 120,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
HDSI	DATA PROCESSING	$ 4,294
KRUPNICK, BOKOR	ACCOUNTING	21,838
FROST, RUTTENBERG	ACCOUNTING	4,500
PERSONNEL PLANNERS	UC CONSULTANT	1,440
DART CHART SYSTEMS	MEDICARE CONSULTANT	22,404
ECONOCARE	PURCHASING CONSLT	2,700
FOX RIVER FOODS	PURCHASING CONSLT	1,500
SACHNOFF & WEAVER	LEGAL	3,459
FINKEL & MARTWICK	LEGAL	8,017
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 70,152

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,247
Unemployment Compensation Insurance	13,029
FICA Taxes	179,825
Employee Health Insurance	201,728
Employee Meals	26,061
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	5,150
TOTAL (agree to Schedule V, line 22, col.8)	$ 496,040

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	14,135
Health Care Worker Background Check	903
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	27,276
TRUST/FRANCHISE/CONTRIB/ETC	6,680
LICENSES & PERMITS	1,218
DUES & SUBSCRIPTIONS	8,960
MGMT CO ALLOCATION	719
TRUST/FRANCHISE/CONTRIB/ETC	(6,680)
Less: Public Relations Expense	(0)
Non-allowable advertising	(27,276)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,135

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
RELATED PARTY	282
Seminar Expense	
EDUCATION & SEMINAR	4,019
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,301

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINTING/DECORATIN	1999	$ 3,946	3	$ 658	$ 1,315	$ 1,315	$ 658	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 3,946		$ 658	$ 1,315	$ 1,315	$ 658	$	$	$	$	$

Facility Name & ID Number WINDMILL NURSING PAVILION # 0031823 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM CARE $2422.**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **371** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **82,125**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **26,061** Has any meal income been offset against related costs? **NA** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: WINDMILL NURSING PAVILION **#0031823** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,772	
	REPAIRS & MAINTENANCE		597	
			0	6,369
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		3,443	
	CONTRACTED LAUNDRY SRVCS		73,008	76,451
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		25,281	
	ELECTRICITY		62,515	
	WATER		15,678	
	CABLE TV - LOBBY		602	
			0	104,076
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,583	
	PAINTING & DECORATING		105	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		1,829	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,275	
	FIRE SERVICE		0	
	CONTRACTED BLDG MAINTENANCE		132,912	
			0	
			0	144,704
7	**OTHER**			
	SCAVENGER		12,487	
	SECURITY SERVICE		0	12,487
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	600	600

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	17,417	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	5,580	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	2,208	
			0	
			0	25,205
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	10,698	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	19,026	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	3,135	32,859
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,586	
			0	1,586
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,860	
			0	2,860
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number WINDMILL NURSING PAVILION **#0031823** **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	120,000	120,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	4,294	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	65,858	
			0	70,152
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	27,276	
	EMPLOYEE WANT ADS	XIX F	14,135	
	CONTRIBUTIONS	VI 20 XIX F	180	
	DUES & SUBSCRIPTIONS	XIX F	8,960	
	LICENSES & PERMITS	XIX F	1,418	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	6,500	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	903	59,372
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		292	
	EQUIPMENT REPAIR & MAINTENANCE		10,118	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	400	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		16,946	
	MESSENGER SERVICE		0	
	BOOKEEPING SERVICES		245,800	273,556

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	179,825	
	UNEMPLOYMENT COMPENSATION	XIX D	13,029	
	WORKERS COMPENSATION INSURANC	XIX D	70,247	
	HOSPITALIZATION INSURANCE	XIX D	201,728	
	EMPLOYEE BENEFITS - OTHER	XIX D	5,150	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	469,979
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	4,019	
	TRAVEL	XIX G	0	
			0	
			0	4,019
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		934	934
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		137,517	137,517
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,542,726

WINDMILL NURSING PAVILION
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	199,914
LESS SALES TAX	(482)
NET FOOD	199,432
TOTAL PATIENT CENSUS	48,357
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	145071
ADD # EMPLOYEE MEALS/DAY	60
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	21900

PATIENT MEALS	145071
ADD EMPLOYEE MEALS	21900
TOTAL MEALS/YEAR	166971
NET FOOD	199432
DIVIDE TOTAL MEALS/YEAR	166971
COST PER MEAL	1.19
TIME EMPLOYEE MEALS	21900
EMPLOYEE MEAL RECLASSIFICATION	26061

WINDMILL NURSING PAVILION
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2002

INCOME PER F/S										5,248,936	
		NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT		2,004,316	469,979	381,994	92,973	403,550	907,686	82,125	1,227,701		2,360,363
ADJUSTMENTS:											
	EQUIPMENT RENTAL/AUTO LEASE	0		1,736			2,760		(4,496)		
	CABLE TV			(602)			602				
	CONTRACT NURSING										17,417
	INTEREST INCOME							(873)			
	NET VENDING COMMISSIONS										
	EMPLOYEE PHYSICAL EXAMS		0				0				
	INSURANCE - EXECUTIVE LIFE		0				0				
	MANAGEMENT FEES						(120,000)		120,000		
	O2 INCOME	0									
	BAD DEBTS						0	0			
	DISCOUNTS EARNED							(456)			
	ANCILLARIES	0					0		0		
	SETTLEMENT INTEREST										
	ADJUSTMENT	(47,671)	0	0	0	0	47,671	0	0		
	PROFIT SHARING	0	0	0	0	0	0	0	0		
	PRIOR EXPENSES	0	0	0	0	0	0	0	0		
	BENEFITS REBILLED	0	0	0	0	0	0	0	0		
	RENT/INTEREST	0	0	0	0	0	0	0	0		
	NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS		1,956,645	469,979	383,128	92,973	403,550	838,719	80,796	1,343,205	5,568,995	2,377,780
PER FINANCIAL STATEMENTS		1,956,645	469,979	383,128	92,973	403,550	838,719	80,796	1,343,205	(320,059)	2,377,780
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS										(320,059)	

WINDMILL NURSING PAVILION - COMPARISONS - 12/31/2002

	ref.	12/31/2002			12/31/2001			DIFF	12/31/2000		
CAPACITY DAYS		54,750			54750.00			0	54900		
CENSUS DAYS		48,357			48179.00			178	50338		
OCCUPANCY %		88.32%			88.00%				91.69%		
SALARIES											
TOTAL General Services	8-1	256,804	4.80%	5.31	242910	4.80%	5.04	13,894	242116	5.21%	4.81
Social Services	12-1	32,638	0.61%	0.67	20544	0.41%	0.43	12,094	25220	0.54%	0.50
TOTAL Health Care and Programs	16-1	1,875,655	35.02%	38.79	1784375	35.28%	37.04	91,280	1731215	37.24%	34.39
Clerical & General Office Expenses	21-1	120,258	2.25%	2.49	109477	2.16%	2.27	10,781	99232	2.13%	1.97
TOTAL General Administration	28-1	227,904	4.26%	4.71	209378	4.14%	4.35	18,526	197633	4.25%	3.93
TOTAL Operation Expense	29-1	2,360,363	44.07%	48.81	2236663	44.22%	46.42	123,700	2170964	46.70%	43.13
ADJUSTED TOTALS											
Food	2-8	172,915	3.23%	3.58	178506	3.53%	3.71	(5,591)	159151	3.42%	3.16
Heat and Other Utilities	5-8	105,134	1.96%	2.17	103295	2.04%	2.14	1,839	95516	2.05%	1.90
Maintenance	6-8	238,689	4.46%	4.94	240658	4.76%	5.00	(1,969)	249919	5.38%	4.96
TOTAL General Services	8-8	864,458	16.14%	17.88	848570	16.78%	17.61	15,888	833711	17.93%	16.56
Administrative	17-8	319,391	5.96%	6.60	288877	5.71%	6.00	30,514	276212	5.94%	5.49
Directors Fees	18-8	0	0.00%	0.00	0	0.00%	0.00	0			
Professional Services	19-8	64,977	1.21%	1.34	50601	1.00%	1.05	14,376	37988	0.82%	0.75
Fees, Subscriptions, Promotions	20-8	26,135	0.49%	0.54	15102	0.30%	0.31	11,033	27006	0.58%	0.54
License Fee-IDPA	Pg21	200	0.00%	0.00	0	0.00%	0.00	200			
License Fee-Other	Pg21	1,218	0.02%	0.03	1275	0.03%	0.03	(57)	858	0.02%	0.02
Clerical & General Office Expenses	21-8	210,585	3.93%	4.35	199141	3.94%	4.13	11,444	184838	3.98%	3.67
Employee Benefits & Payroll Taxes	22-8	496,040	9.26%	10.26	418973	8.28%	8.70	77,067	393840	8.47%	7.82
Payroll Taxes	Pg21	192,854	3.60%	3.99	190485	3.77%	3.95	2,369	190891	4.11%	3.79
W/C Insurance	Pg21	70,247	1.31%	1.45	50339	1.00%	1.04	19,908	45181	0.97%	0.90
Health Insurance	Pg21	201,728	3.77%	4.17	143779	2.84%	2.98	57,949	115515	2.48%	2.29
Inservice Training & Education	23-8	0	0.00%	0.00	0	0.00%	0.00	0			
Travel and Seminar	24-8	4,301	0.08%	0.09	3185	0.06%	0.07	1,116	4664	0.10%	0.09
Other Admin. Staff Transportation	25-8	934	0.02%	0.02	2380	0.05%	0.05	(1,446)	1571	0.03%	0.03
Insurance-Prop.Liab.Malpractice	26-8	141,001	2.63%	2.92	120304	2.38%	2.50	20,697	85500	1.84%	1.70
Other (specify):*	27-8	25,905	0.48%	0.54	25466	0.50%	0.53	439	16497	0.35%	0.33
TOTAL General Administration	28-8	1,289,269	24.07%	26.66	1124029	22.22%	23.33	165,240	1028116	22.11%	20.42
TOTAL Operation Expense	29-8	4,154,967	77.58%	85.92	3914839	77.39%	81.26	240,128	3748944	80.64%	74.48
Real Estate Taxes	33-3	296,495	5.54%	6.13	253044	5.00%	5.25	43,451	239206	5.15%	4.75
Real Estate Legal	Pg10	0	0.00%	0.00	0	0.00%	0.00	0	0	0.00%	0.00
GRAND TOTAL COST	45-8	5,355,442	100.00%	**110.75**	5058319	100.00%	**104.99**	297,123	4648957	100.00%	**92.35**
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		1759550.4	32.86%	**36.39**	1638348.8	32.39%	**34.01**	121,202	1547763	33.29%	**30.75**

WINDMILL NURSING PAVILION - DIAGNOSTICS - 12/31/2002

This report reflects a 365-day year.
Page 3 Column 3 - Other is completely scheduled.
Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.
Total Adj on Page 4 Line 45-7 = Page 5 Line 37.
Deferred maint. adj. on Page 5A Line 1 consists of 658 from Page 22 and 0 from Page 3 Line 6-3.
Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.
Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-466114
Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.
Real estate tax accrual on Page 10 Line 4 = Page 17 Line 32-1.
Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-193491
Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.
Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.
#VALUE!
Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.
Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.
Page 17 Assets = Liabilities & Capital.
Net income on Page 18 Line 7-1 = Page 19 Line 43-2.
Administrative Salaries on Page 3 Line 17-1 = Page 21-A.
Management fees on Page 3 Line 17-3 = Page 21-B.
Professional fees on Page 3 Line 19-3 = Page 21-C.
Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.
Dues, etc. on Page 3 Line 20-8 = Page 21-F.
Travel expenses on Page 3 Line 24-8 = Page 21-G.